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In the Supreme Court of the United States

OCTOBER TERM, 1987

BETHESDA HOSPITAL ASSOCIATION, ET AL., PETITIONERS

v.

OTIS R. BOWEN, SECRETARY OF HEALTH AND HUMAN SERVICES

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

BRIEF FOR THE RESPONDENT

LAWRENCE G. WALLACE
Acting Solicitor General
RICHARD K. WILLARD
Assistant Attorney General
THOMAS W. MERRILL
Deputy Solicitor General
ANDREW J. PINCUS
Assistant to the Solicitor General
Department of Justice
Washington, D.C. 20530
(202) 633-2217

54 pp

QUESTION PRESENTED

Whether the Provider Reimbursement Review Board may consider a health care provider's claim that it is entitled to reimbursement under the Medicare statute for a particular cost when the provider failed to seek reimbursement for that cost from its fiscal intermediary and did not otherwise reserve before the intermediary its right to seek reimbursement for that cost.

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OPINIONS BELOW

The opinion of the court of appeals (Pet. App. 1a-8a) is reported at 810 F.2d 558. The opinion of the district court (Pet. App. 29a-51a) is reported at 608 F. Supp. 1360. The opinion of the Provider Reimbursement Review Board (Pet. App. 52a-58a) is unreported.

JURISDICTION

The judgment of the court of appeals was entered on February 2, 1987, and a petition for rehearing was denied on July 1, 1987 (J.A. 68a). The petition for a writ of certiorari was filed on May 2, 1987, and was granted on October 5, 1987. The jurisdiction of this Court is invoked under 28 U.S.C. 1254(1).

STATUTE INVOLVED

The relevant portions of 42 U.S.C. (& Supp. III) 1395*oo* are set forth in the addendum to this brief.

STATEMENT

1. At the time of the events at issue in this case, all "providers" of health care services to Medicare beneficiaries were reimbursed by the Secretary of Health and Human Services on an annual basis for the "reasonable cost" of those health care services. 42 U.S.C. (& Supp. III) 1395f(b), 1395x(u) and (v)(1)(A).[1] Under this system, the Secretary makes periodic payments to a provider over the course of the year based upon an estimate of the amounts owed to the provider. 42 U.S.C. (& Supp. III) 1395g; 42 C.F.R. 413.60. At the end of the year, the provider submits a claim for reimbursement in the form of a "cost report." See 42 U.S.C. (& Supp. III) 1395f(a); 42 C.F.R. 413.20(a) and (b), 413.24(f).[2] The cost report is "a lengthy document consisting of numerous schedules, worksheets, and supplemental worksheets. * * * [A] cost report, when completed, is approximately three-quarters of an inch thick" (*Athens Community Hospital, Inc.* v. *Schweiker*, 743 F.2d 1, 3 (D.C. Cir. 1984)). Providers list on the worksheet cost items for which they do not seek reimbursement because those cost items supply background information that supports the provider's cost claims. See J.A. 34a-53a, 59a-61a (excerpts from petitioners' cost reports).

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[1] This case concerns payments under "Part A" of the Medicare statute, which provides coverage for "the costs of hospital, related post-hospital, home health services, and hospice care" (42 U.S.C. 1395c). As a result of amendments to the Medicare statute, some providers of such services are now paid predetermined rates for most of those services; other providers continue to receive reimbursement for their "reasonable" costs under the methodology described in the text. See Br. for Resp. 13-14.

[2] The report is due three months after the end of the provider's fiscal year. The provider may obtain a 30-day extension of the due date for "good cause." 42 C.F.R. 413.24(f)(2).

The cost report is submitted to the provider's "fiscal intermediary" for review. The intermediary, generally a private insurance company, is an entity that, pursuant to a contract with the Secretary, acts as the Secretary's agent in reviewing the provider's claims and determining the amount of reimbursement owed to the provider. See 42 U.S.C. (& Supp. III) 1395h; 42 C.F.R. 421.3, 421.100-421.128. The intermediary audits the cost report and issues a Notice of Program Reimbursement specifying the total amount of reimbursement due to the provider and explaining any adjustments to the costs claimed by the provider. See 42 C.F.R. 405.1803. The reimbursement award specified in the Notice of Program Reimbursement is compared to the Secretary's payments to the provider. Any deficiency is paid by the Secretary and any overpayment is repaid by the provider. 42 C.F.R. 405.1803(c), 413.60.

If a provider has timely filed its cost report and is "dissatisfied with [the intermediary's] final determination * * * as to the amount of total program reimbursement due the provider" or has not received a final determination on a "timeiy basis," the provider "may obtain a hearing with respect to such cost report" before the Provider Reimbursement Review Board (PRRB). 42 U.S.C. (& Supp. III) 1395*oo*(a)(1); see also 42 C.F.R. 405.1835.[3] The PRRB is authorized by statute (42 U.S.C. 1395*oo*(d)) to

> affirm, modify, or reverse a final determination of the fiscal intermediary with respect to a cost report and to make any other revisions on matters covered by such a cost report (including revisions adverse to the provider of services) even though such matters were not considered by the intermediary in making such final determination.

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[3] Review by the PRRB is available only if the amount in controversy is $10,000 or more and the provider's request for a hearing is timely filed (42 U.S.C. (& Supp. III) 1395*oo*(a)(2) and (3)).

The Board's decision is final unless the Secretary reverses, affirms, or modifies the decision within 60 days. The Board's decision—or the Secretary's modified decision, if any—is subject to judicial review in federal district court pursuant to the Administrative Procedure Act. 42 U.S.C. (& Supp. III) 1395*oo*(f)(1)); 42 C.F.R. 405.1875-405.1877.[4]

The statute permits providers to take a second, more expeditious route into federal district court in certain circumstances. A provider may obtain direct judicial review of "any action of the fiscal intermediary which involves a question of law or regulations relevant to the matters in controversy whenever the Board determines * * * that it is without authority to decide the question." 42 U.S.C. (& Supp. III) 1395*oo*(f)(1); see also 42 C.F.R. 405.1842.

2. Petitioners are two hospitals that have been certified as providers of services under the Medicare program. In their cost reports for 1980 petitioners computed their claims for malpractice insurance premium reimbursement in accordance with the then-current regulation governing reimbursement for such costs. As the court of appeals observed, "[t]he hospital's cost reports thus included a claim for reimbursement for malpractice insurance costs, but * * * effectuated a 'self-disallowance' " of such malpractice insurance costs in excess of those allowed under the 1979 Rule. Because these hospitals complied with the Secretary's regulation and cost report instructions, there was no need for the fiscal intermediary reviewing their cost reports to make an audit adjustment with respect to the malpractice insurance issue before issuing a Notice of Program Reimbursement" (Pet. App. 5a).

Together with more than 50 other Ohio hospitals, petitioners filed an appeal with the Provider Reimbursement Review Board Challenging the regulation governing the

[4] A final reimbursement decision may be reopended by the intermediary, the Board, or the Secretary in certain circumstances. See 42 C.F.R. 405.1885.

reimbursement of medical malpractice insurance premiums. The Board assumed jurisdiction over the claims of the more than 50 hospitals that had raised this issue in their cost reports. However, it held that it lacked jurisdiction over petitioners' claims because "the malpractice issue was not raised in the * * * cost report(s); nor have any amended costs report(s) been accepted by the intermediary on this issue; nor have any Notices of Program Reimbursement (NPR's) included any denials or adjustments of cost(s) pertaining to the subject issue" (Pet. App. 52a). The Board stated that "the provider must have claimed the cost in its filed cost report to give rise to any controversy. Without any notice of a claimed cost on a cost report, the intermediary is precluded from considering the matter and making any final determination for that particular item * * *. The intermediary's final determination is a statutory prerequisite for Board (or judicial) jurisdiction" (*id.* at 54a). Thus, "[w]hen the provider files a cost report, the particular cost must be claimed therein or [the provider must] state its claim and disclose its position on an issue which was not done in this case" (*ibid.*).[5]

Petitioners sought judicial review of the Board's determination, and the district court reversed (Pet. App. 29a-51a). It concluded that the Board's review of the intermediary's determination "need not be limited to costs claimed by the provider to the intermediary in the cost report" (*id.* at 34a.).[6]

[5] The Board permitted the hospitals that had raised the issue before the intermediary to seek direct judicial review of their challenge to the malpractice insurance cost reimbursement determination, finding that the Board lacked authority to decide the hospitals' claim that the regulation governing reimbursement was invalid (see 42 U.S.C. (& Supp. III) 1395*oo*(f)(1)).

[6] The district court also invalidated the malpractice insurance cost reimbursement rule (Pet. App. 42a-59a).

3. The court of appeals, in turn, reversed the district court's decision. Relying upon its prior decision in *Baptist Hospital East* v. *Secretary of Health & Human Services*, 802 F.2d 860 (6th Cir. 1986), the court concluded that the Board lacks jurisdiction over "claims by providers who • • • self-disallowed reimbursement and • • • failed to challenge the Secretary's regulations before the fiscal intermediary" (Pet. App. 6a). The *Baptist Hospital East* court had observed that the contrary interpretation of the statute—permitting the Board to act where the provider did not claim reimbursement—"renders the second part of the jurisdictional grant [in Section 1395*oo*(d)] meaningless" and "places an irrational gloss on the statute" (802 F.2d at 865). The construction of the statute adopted by the court instead requires a provider "to present a coherent claim for reimbursement at the time it files its cost report. It may not present claims to its intermediary, await the intermediary's decision, and then decide based upon its success before the intermediary whether to raise additional claims before the Board" (*ibid.*).[7]

[7] The court of appeals in the decision below rejected petitioners' claim that a contrary result was required by this Court's decision in *Bowen* v. *Michigan Academy*, 476 U.S. 667 (1986). It observed that *Michigan Academy* "dealt only with the right to judicial review in the absence of meaningful administrative review procedures" (Pet. App. 6a). Here, by contrast, there is an administrative review scheme, and the issue is whether "the *steps* in [the administrative review] process • • • include submission of a 'claim' before the fiscal intermediary as a prerequisite to PRRB and judicial review, in essence an exhaustion requirement" (*id.* at 7a (emphasis in original)).

With regard to the challenge to the malpractice reimbursement rule advanced by the hospitals that had properly preserved the issue, the court held that a newly-promulgated rule governing malpractice cost reimbursement could not be applied retroactively to the cost years at issue in this case. It therefore upheld the district court's award of additional reimbursement to these hospitals. Pet. App. 3a-4a. Petitioners' cost reports have been reassessed under the newly-promulgated rule and additional reimbursement was awarded to petitioners. Petitioners are in error in stating (Br. 11 n.9) that the Secretary may conclude

SUMMARY OF ARGUMENT

When Congress established the Medicare program in 1965, it vested in the Secretary the authority to determine the proper amount of reimbursement due providers of health services to Medicare beneficiaries. However, Congress did not direct the Secretary to create a new administrative apparatus to rule upon providers' reimbursement claims. It anticipated that most providers would nominate a private insurance company to "serve as a fiscal intermediary between themselves and the Federal Government"; the intermediary would enter into an agreement with the Secretary pursuant to which it would "determine the amount of payments due upon presentation of provider bills and make the payments." H.R. Rep. 213, 89th Cong., 1st Sess. 45 (1965). Although the Secretary retained the authority to review the intermediaries' determinations, the statute did not mandate any administrative or judicial review of those determinations.

The Provider Reimbursement Review Board was created by Congress in 1972 in response to providers' complaints about the arbitrariness of intermediaries' reimbursement decisions and the lack of any mechanism for administrative or judicial review of those decisions. The statute governing the Board's jurisdiction states in pertinent part that a provider may obtain a hearing before the Board if

that this new rule should not be applied to providers that failed to challenge the 1979 cost reimbursement rule before their intermediaries. The new rule applies to all cost reports that were open or subject to reopening at the time of the rule's promulgation without regard to whether a provider challenged the prior rule (see 51 Fed. Reg. 11188 (1986)). Petitioners, like the other providers challenging the malpractice insurance cost reimbursement rule, are not satisfied with the level of reimbursement under the newly-promulgated rule and contend that they are entitled to reimbursement under the more favorable pre-1979 rule. It is the latter claim that the court below found to be barred by petitioners' failure to raise the issue in the cost reports.

it "is dissatisfied with a final determination of the organization serving as its fiscal intermediary • • • as to the amount of total program reimbursement due the provider • • •" (42 U.S.C. (& Supp. III) 1395*oo*(a)(1)(A)(i)). The Secretary has construed this language to incorporate what is in effect an exhaustion requirement: a provider's right to obtain a hearing before the Board extends only to reimbursement claims raised by the provider in its cost report submitted to the fiscal intermediary. The question presented in this case is whether the Secretary's interpretation of the statute should be upheld or whether, as petitioners assert, the statute confers a right to a hearing with respect to issues that the provider has failed to present to its intermediary.

The text of Section 1395*oo*(a)(1)(A)(i) makes clear that a provider must present a reimbursement claim to its intermediary in order to obtain the right to invoke the Board's jurisdiction. A provider can be "dissatisfied" with the intermediary's determination only when the intermediary's reimbursement award falls short of the amount of reimbursement that the provider sought before the intermediary. If the intermediary awards the provider the amount of reimbursement that the provider itself requested in its cost report, the provider cannot be dissatisfied with the intermediary's action; it can only be dissatisfied with its own reimbursement request.

The legislative history provides additional support for the Secretary's interpretation of the statute. As we have discussed, Congress added the Board to the preexisting provider reimbursement process in response to providers' requests for an impartial appellate tribunal. Nothing in the legislative history indicates that Congress intended to alter the prior practice under which all reimbursement claims were submitted to the intermediary. Congress's intent—which is manifested as well in several related provisions of the statute—was to create an *appellate* tribunal to review

disputes between a provider and its intermediary. It would be contrary to that intent to require the Board to hear claims in the first instance in the absence of any dispute between the provider and its intermediary.

Finally, the Secretary's interpretation of the statute is eminently reasonable. The Medicare reimbursement process is a vast administrative undertaking: approximately 15,000 providers file annual cost reports that are several hundred pages in length. The primary responsibility for reviewing the cost report and determining the proper amount of reimbursement lies with the fiscal intermediary; the provider's claims clearly can be processed most efficiently if the intermediary considers all of the claims at the same time. Permitting the provider to raise new reimbursement claims before the Board would require the Board to duplicate the intermediary's efforts and expend its own scarce resources performing a task that could have been accomplished by the intermediary. The Secretary's exhaustion requirement also ensures that the Board will have the benefit of the intermediary's expert determination in the event the provider brings the matter before the Board.

Contrary to petitioners' assertions, these policies apply even if a reimbursement claim is one that the intermediary lacks authority to grant because it rests upon a challenge to a regulation. This Court has determined that exhaustion is appropriate in such circumstances to determine whether the claim does in fact turn upon the challenge to the governing regulation, as well as whether the claim is otherwise invalid or cognizable under a different statutory or regulatory provision. See *e.g.*, *Heckler* v. *Ringer*, 466 U.S. 602, 618-620 & n.12, 623-624 (1984). That conclusion is equally applicable to the present context.

Nor does the requirement that all claims be raised in the cost report work a hardship upon providers. Providers are sizeable institutions that already devote substantial resources to the preparation of the cost report; it should require little additional effort to ensure that all reimburse-

ment claims are included in that report. In view of that fact, and the need for clear procedural rules in an administrative undertaking as vast as the Medicare reimbursement process, the Secretary's interpretation of the statute should be upheld.

Even if the Courts were to disagree with our principal submission and conclude that the Board's jurisdiction may be invoked by a claim not previously presented to the intermediary in the cost report, a provider nevertheless should not be able to compel the Board to adjudicate such a claim in every case. The principles underlying the general rule that an appellate court will not consider an issue raised for the first time on appeal are equally applicable here. The Board should therefore be free, in the exercise of its discretion, to conclude that it will not consider a reimbursement claim that was not advanced before the intermediary.

ARGUMENT

THE PROVIDER REIMBURSEMENT REVIEW BOARD LACKS JURISDICTION OVER PETITIONERS' CLAIMS

Appellate tribunals, whether courts or components of administrative agencies, do not as a general rule consider claims raised for the first time on appeal. Requiring a party to present its claims to a trial-level decisionmaker furthers important policies of efficiency and deference to the expertise and record-developing capacity of those decisionmakers. Petitioners' interpretation of the statutory provision at issue in this case would turn that principle on its head by *requiring* an appellate tribunal—the Provider Reimbursement Review Board (PRRB)—to consider a reimbursement claim asserted by a provider even though the provider failed to present the claim to its fiscal intermediary. Nothing in the relevant statutory language or legislative history suggests that Congress intended such an extraordinary result. To the contrary, Congress created only a limited appellate remedy when it established the

PRRB. Fiscal intermediaries were to remain the principal decisionmakers in the reimbursement process; the Board's role was that of a referee in disputes between providers and their intermediaries. Because no such dispute can arise when a provider fails to raise a claim before its intermediary, a provider is not entitled to a hearing before the Board with respect to a claim that the provider did not first raise before the intermediary.[8]

A. A Provider May Invoke The Board's Jurisdiction Only When It Seeks Review Of An Issue Raised Before Its Fiscal Intermediary

1. Section 1395*oo* Limits The Board's Jurisdiction to Cases in which the Provider Seeks Review of a Claim Raised Before Its Intermediary

The starting point in any case of statutory construction is, of course, the language of the statute being construed. See, *e.g.*, *United States* v. *James*, No. 85-434 (July 2, 1986), slip op. 6. The relevant statute here is 42 U.S.C. (& Supp. III) 1395*oo*, which both establishes the Provider Reimbursement Review Board and delineates the Board's authority. We agree with petitioners (Br. 13-14) that Section 1395*oo*(a)(1)(A)(i) is the subsection most directly relevant in determining the circumstances in which a provider may invoke the Board's jurisdiction. We submit, however, that petitioners' interpretation of that provision cannot be reconciled with the statutory text. Viewed in the context of Section 1395*oo* as a whole, that language makes clear that the PRRB may only consider cases in which a provider seeks review of an issue that the provider previously raised before its fiscal intermediary.

a. Section 1395*oo*(a)(1)(A)(i) states that a provider may "obtain a hearing [before the PRRB] with respect to

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[8] Under the Secretary's interpretation of the statute, a provider may raise a claim before its intermediary either by claiming reimbursement for a particular amount in the cost report or by expressly noting its disagreement with the policy or regulation governing the reimbursement issue. See Pet. App. 52a-54a.

[its] cost report" if the provider "is dissatisfied with a final determination of the organization serving as its fiscal intermediary * * * as to the amount of total program reimbursement due the provider * * *." As a matter of both common sense and common usage, a provider can be "dissatisfied" with the intermediary's determination only when the intermediary's reimbursement award falls short of the amount of reimbursement that the provider sought before the intermediary. If the intermediary approves the provider's treatment of its own costs and awards the provider the amount of reimbursement that the provider itself requested in its cost report, the provider cannot be dissatisfied with the intermediary's action; it can only be dissatisfied with the request for reimbursement set forth in its own cost report. As one lower court has observed, "[i]t would be anomalous * * * to say that a provider can appeal only when 'dissatisfied' while allowing the provider to obtain review of an intermediary's refusal to reimburse the provider for a cost it did not even claim. * * * If a provider is unhappy with the reimbursement the intermediary allowed in such a case, it is the fault of the provider and not of the intermediary." *Athens Community Hospital, Inc.*, 743 F.2d 1, 6 (D.C. Cir. 1984); see also *North Broward Hospital District*, 808 F.2d 1405, 1409 (11th Cir. 1987), petition for cert. pending, No. 86-1986; *Community Hospital* v. *Health and Human Services*, 770 F.2d 1257, 1262 (4th Cir. 1985).

Petitioners assert (Br. 15-16) that a provider is "dissatisfied" within the meaning of Section 1395*oo*(a)(1)(A)(i), and therefore entitled to invoke the Board's jurisdiction, if the provider experiences a subjective feeling of dissatisfaction upon learning of the total reimbursement award. But the statute does not authorize review by the Board when the provider is "dissatisfied" in some general sense entirely unrelated to the intermediary's actions. It specifically requires that the provider be dissatisfied with a "final * * * determination of the * * * fiscal intermediary." Petitioners' interpretation essentially

reads the dissatisfaction language out of the statute: on their reading, any provider that seeks Board review of the intermediary's determination would be, simply by virtue of its decision to seek further review, a dissatisfied provider. Such a construction, which would render a provision of the statute essentially meaningless, is not favored. See *Bowsher* v. *Merck & Co.*, 460 U.S. 824, 833 (1983) (referring to the "settled principle of statutory construction that [the Court] must give effect, if possible, to every word of the statute"); *Fidelity Federal Savings & Loan Ass'n* v. *De La Cuesta*, 458 U.S. 161, 165 (1982).[9]

Other provisions of the statute confirm that a provider is "dissatisfied" only when the intermediary does not award the provider all of the reimbursement that the pro-

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[9] Petitioners state (Br. 15) that the statute requires "that the provider be dissatisfied with the *total* amount of reimbursement offered in the NPR," and that "the dissatisfaction [need not] be with respect to a particular intermediary audit adjustment" (emphasis in original). We agree that the provider must be dissatisfied with the total award. But the statute requires dissatisfaction with the "final * * * determination of * * * the fiscal intermediary" as to the total award. And the provider can be dissatisfied with the *intermediary's* determination of the amount of reimbursement only if the total award is less than the amount of reimbursement sought by the provider because the intermediary did not accept one or more of the provider's reimbursement claims.

Petitioners also state (Br. 15) that the provider must "be dissatisfied at the time it receives its [notice of program reimbursement], not beforehand." But that test is satisfied by our interpretation of the statute—the provider is dissatisfied because it learns that the intermediary has rejected one of its claims for reimbursement. Petitioners assert (Br. 16) that our reading of the statute is "not plausible" because Congress would not have intended to require providers to advance in the cost report a reimbursement claim that the intermediary lacked the authority to resolve in their favor, such as a claim resting upon a challenge to the Secretary's reimbursement regulations. As we discuss below (at 15), however, Congress imposed precisely such a requirement when it amended the statute in 1980. In addition, petitioners ignore the fact that their construction of the statute would allow any reimbursement claim, even a claim that does not rest upon a challenge to a regulation, to be raised before the Board in the first instance.

vider has claimed. Cf. *Commissioner* v. *Engle*, 464 U.S. 206, 223 (1984) (referring to other, related, portions of a statute in order to ascertain the meaning of a particular provision); *FBI* v. *Abramson*, 456 U.S. 615, 625-627 (1982) (same). First, Congress denominated the administrative body established by Section 1395*oo* the "Provider Reimbursement *Review* Board" (see 42 U.S.C. 1395*oo*(a)). The term "review" in the Board's name indicates that the Board's function is to review the reimbursement determinations of fiscal intermediaries, not to make those determinations in the first instance.

Second, Board review is available to a provider only when "the amount in controversy is $10,000 or more." 42 U.S.C. 1395*oo*(a)(2); see also 42 U.S.C. 1395*oo*(b) (group appeals permissible if "the amount in controversy is, in the aggregate, $50,000 or more"). Petitioners' interpretation of the statute would make the amount in controversy requirement difficult to administer. When the intermediary rejects a claim for reimbursement set forth in the cost report, it is easy to establish the amount in controversy: the intermediary's determination need only be compared to the provider's initial claim. If a provider may raise new claims before the Board, however, the Board will have to examine for itself in the first instance the amount placed in controversy by the provider's claim. Petitioner's construction would also make it easy to evade the amount in controversy limitation. A provider dissatisfied with its intermediary's determinations but otherwise unable to obtain Board review because $10,000 was not at stake could reach the required dollar amount by simply adding several new reimbursement claims at the time of its appeal to the Board. Since it could be so easily circumvented, the amount in controversy requirement would cease to be a meaningful limit upon the Board's jurisdiction.

Finally, any uncertainty about the meaning of Section 1395*oo*(a)(1)(A)(i) is resolved by the portion of Section 1395*oo*(f)(1) that permits expedited judicial review of certain reimbursement determinations when the Board determines that it lacks the authority to adjudicate the provider's claim. Section 1395*oo*(f)(1) states that "[p]roviders shall * * * have the right to obtain judicial review of any action of the fiscal intermediary which involves a question of law or regulations relevant to the matters in controversy whenever the Board determines * * * that it is without authority to decide the question." This provision, which was added to the statute in 1980, is the only part of Section 1395*oo* other than Section 1395*oo*(a)(1)(A)(i) that addresses the prerequisites for Board jurisdiction. By stating that a provider may obtain "judicial review of any *action* of the fiscal intermediary" (emphasis added), Congress made clear that the rejection (or at least nonacceptance) by the intermediary of the provider's claim is a condition precedent for expedited judicial review.[10] Since the expedited review provision was intended to provide a direct route into court for all claims resting upon a controlling question of law or regulation that otherwise would be considered by the Board (see H.R.

[10] Petitioners may argue that the intermediary "acts" when it awards the amount claimed in the cost report and that a provider may challenge that action by raising a new claim before the PRRB. However, that interpretation of Section 1395*oo*(f)(1) would have the disfavored result of allowing a provider to seek judicial review of a claim that was never addressed on the merits by any adjudicatory body. See page 31 note 20, *infra*. In addition, the legislative history of the expedited judicial review provision makes clear that judicial review is available only in the event of a dispute between the provider and its intermediary. See H.R. Rep. 96-1167, 96th Cong., 2d Sess. 394 (1980) (emphasis added) ("[u]nder present law, a provider's *dissatisfaction with a particular determination made by its fiscal intermediary* on the basis of a regulation issued by the Secretary must first be brought to the Board, even though the Board may not have the authority to reverse or overrule the regulation. * * * [The statute] addresses this problem by giving medicare providers the right to obtain immediate judicial review in instances where the Board determines that it lacks jurisdiction to grant the relief sought").

Rep. 96-1167, 96th Cong., 2d Sess. 394 (1980)), the prerequisite for expedited review—consideration of a claim by the intermediary—must also be a prerequisite for Board action.[11]

The language in Section 1395*oo*(f)(1) is therefore highly probative of the meaning of the dissatisfaction requirement in Section 1395*oo*(a)(1)(A)(i): in each case further review is available only if the claim was first raised before the intermediary. Cf. *Japan Whaling Ass'n* v. *American Cetacean Society*, No. 85-954 (June 30, 1986), slip op. 14, 16-17 (relying on subsequent amendment as an aid in interpreting language in prior statute).[12]

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[11] Relying upon *Tallahassee Memorial Regional Medical Center* v. *Bowen*, 815 F.2d 1435 (11th Cir. 1987), petition for cert. pending, No. 87-830, petitioners contend (Br. 22-23) that Section 1395*oo*(f)(1) supports their interpretation of Section 1395*oo*(a)(1)(A)(i). The court of appeals in that case concluded that a provider that failed to present to its intermediary a claim based upon a challenge to a reimbursement regulation could obtain expedited judicial review with respect to that claim; the court found that such a claim satisfied the requirements of Section 1395*oo*(a)(1)(A)(i) and that the provider was therefore entitled to expedited judicial review (see 815 F.2d at 1461). The court of appeals' conclusion is based upon two fundamental errors. First, the court of appeals ignored the fact that expedited judicial review is available only with respect to an "action of the fiscal intermediary"; review cannot be had under this provision where the claim was never presented to the intermediary (see page 15 & note 10, *supra*). Second, as we have discussed (at 11-12), Section 1395*oo*(a)(1)(A)(i) does not authorize a provider to invoke the Board's jurisdiction with respect to a claim not previously presented to the provider's intermediary.

[12] Petitioners contend (Br. 17-18) that the passage of the statute stating that a provider that satisfies the jurisdictional requirements "may obtain a hearing with respect to such cost report" (42 U.S.C. (& Supp. III) 1395*oo*(a)) indicates that the hearing before the Board "concerns the cost report as a whole." In the first place, the scope of the hearing before the Board is a matter separate from the prerequisites for invoking the Board's jurisdiction. More importantly, Congress's reference to the "cost report" is undoubtedly a shorthand

b. The courts of appeals have frequently referred to Section 1395*oo*(d), the provision of the statute setting forth the Board's remedial powers, in ascertaining the circumstances under which a provider may invoke the Board's jurisdiction. See, *e.g.*, *Adams House Health Care* v. *Heckler*, 817 F.2d 587, 594 (9th Cir. 1987), petition for cert. pending, No. 87-443; *Athens Community Hospital* v. *Schweiker*, 743 F.2d at 8-9. This approach, however, ignores the fundamental distinction between the power of a provider to invoke the jurisdiction of the Board (the subject of Section 1395*oo*(a)) and the power of the Board once its jurisdiction has been invoked (the subject of Section 1395*oo*(d)). Like petitioners (Br. 14), we believe that these two issues are distinct, and that the scope of the Board's remedial powers in a case in which the relevant jurisdictional requirements have been satisfied is of little relevance in defining the content of those jurisdictional requirements. To the extent it is relevant, however, Section 1395*oo*(d) supports the construction of the statute for which we contend.

Section 1395*oo*(d) grants to the Board "the power to affirm, modify or reverse a final determination of the fiscal intermediary with respect to a cost report," and empowers the Board to "make any other revisions on matters covered by such cost report (including revisions adverse to the provider of services) even though such matters were not considered by the intermediary in making [its] final determination" (42 U.S.C. 1395*oo*(d)). Congress made two separate grants of remedial authority in this subsection because the two grants serve different purposes. The first

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way of referring to reimbursement claims contained in the cost report. Congress would simply have had no reason to authorize the Board to conduct a hearing with respect to costs contained in the cost report for which the provider did *not* claim reimbursement; its intent was limited to providing for review of claims that were raised before the intermediary. See pages 22-25, 27-28 note 16, *infra*.

category—"the power to affirm, modify, or reverse a final determination of the fiscal intermediary"—mirrors the scope of the Board's jurisdiction. Just as the Board's jurisdiction may be invoked when a provider seeks review of an intermediary determination, the Board is endowed with the power to "affirm, modify, or reverse" that determination. If the existence of a prior intermediary determination were irrelevant to the Board's jurisdiction, there would have been no reason for Congress to single out this component of the Board's remedial power. Congress could simply have authorized the Board to act with regard to all "matters covered by [a] cost report."

The second, more general grant of remedial authority gives the Board leeway to act with respect to matters not addressed by the intermediary when, in a case properly before it, the Board in the exercise of its discretion deems such action appropriate. Thus, in describing the Board's remedial power, Congress stated that "[b]ased upon examination of all of the evidence, the [Board] may find in whole or in part for the provider or for the Government (*including a finding based upon the evidence before it that the provider owes sums in addition to the amount raised in the appeal*)" (H.R. Rep. 92-231, 92d Cong., 1st Sess. 108-109 (1971) (emphasis added)). This authority is likely to be most frequently invoked to allow

> the PRRB to revise aspects of the reimbursement calculation not actually contested by the provider, and possibly not considered by the intermediary (because not claimed for reimbursement by the provider), when such revision is necessary to accommodate other PRRB revisions of matters that were claimed by the provider, decided adversely by the intermediary, and then contested by the provider to the PRRB.

Athens Community Hospital, Inc. v. *Schweiker*, 743 F.2d at 9; see also *North Broward Hospital District* v. *Bowen*, 808 F.2d at 1409; *Community Hospital* v. *Health & Human Services*, 770 F.2d at 1262.

The Secretary has gone further, however, stating that, in an appropriate case, this discretionary authority may also be invoked with respect to matters unrelated to the issues raised by the provider before its intermediary. In *University Park Convalescent Center* v. *Aetna Life and Casualty Co.*, [New Developments] Medicare & Medicaid Guide (CCH) ¶ 30,993 (HCFA 1981), for example, the provider challenged the intermediary's treatment of certain costs incurred in connection with a capital expenditure. The Secretary's designee found against the provider with respect to its claim; he further stated that the evidence before the Board concerning that this issue indicated that the provider's physical plant had been purchased from corporations owned by the provider's relatives. Observing that "[t]his purchase appears to have a significant effect on the amount of Medicare reimbursement," the Secretary's designee concluded that "further inquiry into this transaction would be in order to determine whether reimbursement should be limited pursuant to the related-organization principle" and remanded the matter to the Board (*id.* at 10105). In other words, because the evidence before the Board had revealed a potentially serious error in the reimbursement determination, the Board had the power to consider that error and to modify the intermediary's award if that course of action proved appropriate, even though the particular reimbursement issue had not been raised before the intermediary. See also page 35, *infra*.

The Board's discretionary remedial authority provides no support for petitioners' contention that a provider has a right to a hearing before the Board with regard to claims not raised before the intermediary. First, the provider's right to invoke the Board's jurisdiction is set forth in Section 1395*oo*(a)(1)(A)(i), not Section 1395*oo*(d). A provider

may obtain discretionary relief from the Board only if he first satisfies the requirements of Section 1395*oo*(a)(1)(A)(i)—and one of those requirements limits the provider's right to Board review to issues that were raised before the intermediary.

Second, even when all of the requirements of Section 1395*oo*(a)(1)(A)(i) have been satisfied and a case is properly before the Board, the provider cannot compel the Board to make revisions in the intermediary's reimbursement award with respect to matters not raised before the intermediary because the Board's authority to act with respect to such issues is discretionary. Congress provided that the Board "shall have the power" to make such revisions, but did not direct that this authority be exercised in any particular manner. See *St. Luke's Hospital* v. *Secretary of Health and Human Services*, 810 F.2d at 327; compare 28 U.S.C. 2106 (grant of remedial authority to federal appellate courts); see also page 30 note 20, *infra*. Due to the complete absence of any standards restricting the Board's discretion in exercising this residual remedial authority, the Board's decision whether to exercise that authority is not subject to judicial review. See 5 U.S.C. 701(a)(2) (no judicial review of "agency action • • • committed to agency discretion by law"); *Heckler* v. *Chaney*, 470 U.S. 821, 830 (1985) (Section 701(a)(2) bars review "if the statute is drawn so that a court would have no meaningful standard against which to judge the agency's exercise of discretion").

In any event, the scope of the Board's discretionary remedial authority, and the reviewability of the Board's decisions with regard to the exercise of that authority, are not at issue in the present case. Petitioners have failed to satisfy the threshold requirements for Board jurisdiction

set forth in Section 1395*oo*(a)(1)(A)(i)—they did not have a case that was properly before the Board because they did not seek Board review of a matter raised before their intermediaries.[13]

2. The Legislative History of Section 1395*oo* Confirms the Limited Nature of a Provider's Right to Invoke the Board's Jurisdiction

The Provider Reimbursement Review Board was not part of the administrative structure created by the original Medicare statute. That statute simply directed the Secretary to "periodically determine the amount which should be paid under this part to each provider of services with respect to the services furnished by it" and to pay to the provider "the amounts so determined." Pub. L. No. 89-97, § 102(a), 79 Stat. 297, codified, as amended, at 42 U.S.C. (& Supp. III) 1395g. A provider that "wishe[d] to have [Medicare] payments • • • made through a national, State, or other public or private agency or organization," such as a private insurance company, could nominate an agency or organization for that purpose; the Secretary was authorized to "enter into an agreement with such agency or organization providing for the determination by such agency or organization (subject to such review by the Secretary as may be provided for by the agreement) of the amount of the [Medicare] payments required • • • to be made to such providers, and for the making of such payments by such agency or organization to such providers." Pub. L. No. 89-97, § 102(a), 79 Stat. 297, codified, as amended, at 42 U.S.C. (& Supp. III) 1395h. The statute contained no provision for administrative or judicial review of these reimbursement determinations. Cf. *Schweiker* v. *McClure*, 456 U.S. 188 (1982); *United States* v. *Erika, Inc.*, 456 U.S. 201 (1982) (describing absence of administrative or judicial review of claims under "Part B" of Medicare).

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[13] Petitioners sought to raise before the Board only a single issue—the claim regarding reimbursement for medical malpractice insurance costs that they failed to present to their intermediaries.

Congress emphasized the "considerable role for the participation of private organizations in the administration of [the Medicare program]." H.R. Rep. 213, 89th Cong., 1st Sess. 45 (1965); see also S. Rep. 404, 89th Cong., 1st Sess. Pt. 1, at 52 (1965). It anticipated that most providers would nominate a private organization to "serve as a fiscal intermediary between themselves and the Federal Government"; the intermediary would enter into an agreement with the Secretary pursuant to which it would "determine the amount of payments due upon presentation of provider bills and make the payments" (H.R. Rep. 213, *supra*, at 45). The Secretary was authorized to delegate other administrative duties to intermediaries such as "providing consultative services to assist providers to establish and maintain necessary fiscal records and otherwise to qualify as providers of services, serving as a center for communicating with providers, making audits of provider records, and performing related functions." *Ibid.*; see also S. Rep. 404, *supra*, at 52.

During the congressional hearings held prior to the adoption of the 1972 amendments to the Medicare statute, a number of provider representatives complained of the arbitrariness of intermediary determinations and voiced dissatisfaction about the lack of administrative and judicial review. Representatives of the Federation of American Hospitals testified that the statute "contains no provisions for administrative recourse by providers from the decisions of intermediaries"; they stated that "this is one of those rare instances in our Anglo-Saxon tradition where a party with a grievance has no recourse from a decision of the interested party on the other side of the controversy." *Medicare and Medicaid: Hearings Before the Subcomm. on Medicare-Medicaid of the Senate Comm. on Finance* 91st Cong., 2d Sess. Pt. 2, at 432 (1970). The Federation representatives also asserted that hearings held by intermediaries were "partial and limited,"

and that "[c]onflicting interpretations by different intermediaries remain[ed] unresolved" due to the absence of a "national appeals mechanism" (*ibid.*). Testimony by other groups representing providers' interests was to the same effect. *Id.* at 557, 622-628 (statements of various provider representatives); see also *Social Security and Welfare Proposals: Hearings Before the House Comm. on Ways and Means*, 91st Cong., 2d Sess. Pt. 4, at 1062, 1071, 1149, 1152, 1180 (1970) (same); *Social Security Amendments of 1970: Hearings Before the Senate Comm. on Finance on H.R. 17550*, 91st Cong., 2d Sess. Pt. 3, at 967-968, 972 (1970) (statement of Dr. Martin Steinberg, American Hospital Association); *Social Security Amendments of 1971: Hearings Before the Senate Comm. on Finance on H.R. 1*, 92d Cong., 1st and 2d Sess. Pt. 5, at 2285 (1972) (statement of Richard M. Loughery, American Hospital Association).

The congressional committee reports describing the provision of the 1972 amendments that established the Provider Reimbursement Review Board stated that "[u]nder present law there is no specific provision for an appeal by a provider of services of a fiscal intermediary's final reasonable cost determination." H.R. Rep. 92-231, 92d Cong., 1st Sess. 108 (1971); see also S. Rep. 92-1230, 92d Cong., 2d Sess. 248 (1972). The committees recognized that "HEW has developed administrative procedures to assist providers and intermediaries to reach reasonable and mutually satisfactory settlements of disputed reimbursement items," but concluded "that it is desirable to prescribe in law a specific procedure for settling disputed final determinations applying to the amount of program reimbursement." H.R. Rep. 92-231, *supra*, at 108; See also S. Rep. 92-1230, *supra*, at 248-249. In describing the Board's authority, Congress stated that a provider that filed a timely cost report could "appeal [to the Board] an adverse final decision of the fiscal intermediary" with respect to the period covered by the cost report. H.R. Rep. 92-231, *supra*, at 108; see also S. Rep. 92-1230, *supra*, at 248.

The 1972 amendments did not create an action for judicial review of the Board's reimbursement determinations. A provider was entitled to judicial review only if the Secretary reversed the Board's determination. See Pub. L. No. 92-603, § 243(a), 86 Stat. 1420. Two years later, Congress provided for review of all Board decisions and of decisions of the Secretary affirming a Board determination. See Pub. L. No. 93-484, § 3(a), 88 Stat. 1459. Finally, Congress in 1980 completed the judicial review structure by adding the expedited judicial review provision. See page 15, *supra*.

The evolution of the Medicare statute, together with the legislative history specifically addressing the powers of the PRRB, make clear that a provider may invoke the Board's jurisdiction only with respect to a claim previously raised before the provider's intermediary. An administrative structure for evaluating reimbursement claims—the intermediary system—was already in place when Congress established the PRRB. Providers necessarily presented all reimbursement claims to their intermediaries, because the intermediaries had sole responsibility for making reimbursement determinations. Nothing in the statutory language or legislative history indicates that Congress intended to displace the preexisting responsibility of intermediaries to hear and determine all reimbursement claims in the first instance. The Board was instead created in response to providers' complaints about the unfairness of intermediaries' determinations and their requests for an impartial review panel. It was placed atop the existing administrative structure to serve as an appellate body to referee disputes between providers and their intermediaries. Petitioner's claim that a provider may require the Board to make reimbursement determinations on a de novo basis is squarely inconsistent with Congress's conception of the Board as an appellate tribunal whose role is to review intermediary determinations.

Petitioners contend (Br. 16, 27) that Congress, in creating the PRRB in 1972, did not intend to require presentation of a reimbursement claim to the intermediary in a case in which the claim is based upon a challenge to a reimbursement regulation. But nothing in the legislative history of the statute establishing the PRRB indicates that Congress intended to change the preexisting practice of presenting all reimbursement claims to the intermediary. Moreover, despite the fact that the PRRB, like the intermediary, has no authority to overturn a regulation issued by the Secretary (see 42 C.F.R. 405.1867 (1987)), Congress initially required all providers to go through a Board hearing concerning reimbursement claims even if the only issue presented was a regulatory challenge that the Board could not resolve. That requirement was eliminated only upon the adoption of the expedited judicial review provision in 1980. Since Congress prior to 1980 did not distinguish between claims resting upon challenges to regulations and all other claims, there is no basis for assuming that Congress in 1972 intended to exempt such claims from the general rule regarding the presentation of claims to the intermediary. To the contrary, Congress expressly reaffirmed, in the express language of the expedited judicial review provision, the requirement that such claims be presented to the intermediary. See page 15, *supra*. In sum, the legislative history strongly reinforces the conclusion that a provider is entitled to a Board hearing only with respect to reimbursement claims raised before the intermediary.

3. The Secretary's Interpretation of Section 1395*oo* Should be Upheld Because It is Reasonable

In any event, the Secretary's determination that a provider may seek review only of claims initially presented to the intermediary should be upheld because it is " 'based on

a permissible construction of the statute.' " *NLRB* v. *United Food & Commercial Workers Union*, No. 86-594 (Dec. 14, 1987), slip op. 10 (quoting, *Chevron U.S.A. Inc.* v. *NRDC*, 467 U.S. 837, 843 (1984)).[14]

a. The Secretary's interpretation of the statute furthers important policies of finality and administrative efficiency. Approximately 15,000 providers participate in the Medicare cost reimbursement process; each provider must file an annual cost report that is several hundred pages in length. The Secretary is responsible for reviewing these claims and determining the amount of reimbursement owed to each provider in as timely and efficient a manner as possible while maintaining the level of accuracy necessary to protect the public fisc against improper claims.[15] The primary responsibility for reviewing a provider's cost report and determining the amount of reimbursement owed to the provider lies with the fiscal intermediary. Indeed, prior to the creation of the PRRB, the intermediary had sole responsibility for this task. See pages 21-22, *supra*.

The vast undertaking of processing and reviewing these claims for reimbursement can be performed efficiently only if providers are required to include all of their reimbursement claims in the cost reports that trigger the reim-

[14] Petitioners suggest (Br. 24) that deference to the Secretary's interpretation is not appropriate because the question in this case involves "the relationship of the agency to the federal courts." But the question here concerns only what steps must be taken by a provider to secure review – the Secretary has not attempted to confine or restrict the right of judicial review. The substance of the issue involves the allocation of decisional responsibility within the agency itself, surely a subject upon which the agency's views are entitled to special weight.

[15] Providers obviously have a considerable interest in the timely processing of reimbursement claims. Cf. *Bowen* v. *City of New York*, No. 84-1923 (June 2, 1986), slip op. 13 (noting the interest of program beneficiaries in the efficient processing of claims).

bursement process. Because the intermediary is responsible for evaluating all of the reimbursement claims included in the cost report, the provider's reimbursement claims can thus be comprehensively considered. Accordingly, where several reimbursement claims involve similar aspects of a provider's operations or necessitate the application of the same accounting or legal principles, the intermediary would be able to treat the issues together, thus eliminating redundant effort and ensuring internally consistent results.

Permitting the provider to raise new reimbursement claims before the Board would require the Board to duplicate the intermediary's efforts by examining a portion of the cost report that was likely reviewed by the intermediary in connection with other reimbursement claims. In addition, the Board would be required to devote its limited resources to a matter that might well have been resolved by the intermediary had the provider raised the claim in its cost report. That, in turn, would distract the Board's attention from its principal responsibility – resolving disputes between providers and their intermediaries. Permitting the provider to revise its claim after the intermediary's issuance of the Notice of Program Reimbursement would therefore " 'make the PRRB the tribunal of original jurisdiction, eliminating a tier of review, and [have the effect of] possibly substantially slowing the reimbursement process for other providers.' " *Athens Community Hospital, Inc.*, 743 F.2d at 6-7 (citation omitted); see also *North Broward Hospital District* v. *Bowen*, 808 F.2d at 1409; cf. *Thomas* v. *Arn*, 474 U.S. 140, 146-148 (1985) (applying similar rationale to uphold a rule making the filing of objections in the district court a prerequisite to appealing a magistrate's determination to the court of appeals).[16]

[16] Petitioners assert (Br. 32-33) that Congress intended the Board to be a tribunal of original jurisdiction. While the Board does have authority to gather new evidence on the matters brought before it (see 42 U.S.C. (& Supp. III) 1395*oo*(a), (c)), the legislative history makes clear that the Board was not to conduct a de novo review of all of the prior

The Secretary's approach also protects the integrity of the cost reimbursement process. Allowing providers to assert new reimbursement claims before the Board gives providers the opportunity of utilizing two completely different reimbursement strategies—one strategy directed toward the intermediary and one directed toward the Board and the courts. The provider could first allocate its costs in a manner that could be upheld on the basis of favorable rulings by the intermediary; if that strategy was not successful, the provider could adopt an entirely new approach, such as challenging the validity of the regulations governing various reimbursement determinations. Strategic maneuvers of this sort have no place in an administrative process that must be efficient if it is to be effective. The Secretary's interpretation of the statute requires a provider to "present a coherent claim for reimbursement at the time it files its cost report"; the provider may not "present claims to its intermediary, await the intermediary's decision, and then decide based upon its success before the intermediary whether to raise additional claims before the Board." *Baptist Hospital East* v. *Secretary of Health and Human Services*, 802 F.2d 860, 865 (6th Cir. 1986); see also *Athens Community Hospital, Inc.* v. *Schweiker*, 743 F.2d at 6.[17]

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determinations. The hearing before the Board is limited to the issues upon which the provider and the intermediary disagree. Indeed, the genesis of the Board's power to conduct such a hearing was most likely providers' complaints that the hearings conducted by intermediaries were biased because the intermediary had already taken a position contrary to the provider. See pages 22-23, *supra*.

[17] Petitioners suggest (Br. 33-36) that a provider could not engage in this conduct because the provider must fill out the cost report in accordance with the applicable regulations and the intermediary will simply disallow any improperly-claimed costs. Contrary to petitioners' apparent view, however, submitting information on cost reports is not a wholly mechanical process. Accounting and legal judgments come into play in determining the proper allocation of costs. A provider plainly has sufficient leeway to engage in behavior of the sort described in the text.

Requiring that claims be raised before the intermediary in the first instance also ensures that the Board will have the benefit of the intermediary's expert assessment of the provider's claim. One of the principles underlying the doctrine of exhaustion of administrative remedies is that, because "agency decisions are frequently of a discretionary nature or frequently require expertise, the agency should be given the first chance to exercise that discretion or to apply that expertise" (*McKart* v. *United States*, 395 U.S. 185, 194 (1969)). Fiscal intermediaries have considerable expertise in the application of the cost reimbursement rules. Most intermediaries are private insurance companies well versed in the application of reimbursement principles to medical institutions. And, because they apply the Medicare reimbursement rules on a daily basis, intermediaries are familiar with the particular requirements of those rules. In addition, the intermediary may have gained familiarity with the provider's operations and accounting techniques by virtue of its review of past cost reports. The Secretary's conclusion that the Board is entitled to the benefit of that expertise is plainly reasonable.[18]

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[18] Petitioners repeatedly attempt to deprecate the importance of the intermediary's role in the cost reimbursement process, characterizing the intermediary as a "government contractor" (Br. 22), asserting (Br. 32-33) that the cost report is "simply an accounting document" and suggesting that "[t]he intermediary's job is to audit that document in an accounting sense, not to act as a tribunal." Although the cost report is an accounting document in the sense that it presents a breakdown of the provider's costs, the intermediary must determine whether the provider correctly allocated its costs in the manner required by the Medicare cost reimbursement rules. The proper application of those rules frequently involves discretion and judgment, and those determinations, which formerly were the intermediary's alone, are now committed to the intermediary in the first instance. Indeed, the legislative materials relating to the adoption of the original Medicare Act are replete with references to the importance of the intermediary's role in the cost reimbursement process. See page 21-22, *supra*.

Petitioners also state (Br. 32) that the Board will not be deprived of the intermediary's expertise with respect to claims presented to the

Finally, the Secretary's interpretation of the statute imposes no significant burden upon providers. Every provider must file a cost report in order to obtain reimbursement under the Medicare program. The Secretary's construction of the statute simply requires that the provider include all of its reimbursement claims in the report. And this requirement does not set a trap for the unwary. Unlike other provisions of the social security laws that affect individual citizens who lack the sophistication or the access to legal services needed to identify and comply with strict procedural rules, the Secretary's interpretation of the statute at issue here affects health care providers that are sizeable businesses. These institutions already are required to devote substantial resources to compliance with the Medicare statute. Those existing compliance mechanisms can easily be adapted to ensure that the institution claims all of its costs in its cost report.[19]

Board in the first instance because the intermediary appears as a party in proceedings before the Board. But the intermediary's participation will be hampered by the fact that it was unable to consider the question at the time it evaluated the cost report and therefore could not obtain relevant background information from the provider.

[19] The court in *St. Luke's Hospital* v. *Secretary of Health and Human Services*, *supra*, analogized the Board to other types of appellate tribunals and concluded that, like those other tribunals, the Board is endowed with the discretion to hear claims not presented below (see 810 F.2d at 330). The flaw in this analogy is that it ignores the fact that Congress did not intend to create a general appellate tribunal; it established the Board specifically to consider disputes between providers and intermediaries. In addition, the appropriate scope of a provider's right to invoke the Board's jurisdiction must be evaluated with reference to the enormous administrative task of performing reimbursement determinations and the relatively sophisticated nature of the parties seeking reimbursement. In these circumstances the Secretary reasonably concluded that strict procedural rules best comport with the congressional mandate to establish an efficient system for the calculation of the amount of reimbursement owed to providers.

b. Petitioners nevertheless contend that a provider should not be required to raise before its intermediary a reimbursement claim that the intermediary lacks the authority to grant. As an initial matter, we note that the statute draws no distinction between claims that the intermediary may rule upon and those which it may not. To the contrary, in amending Section 1395*oo* to provide for expedited judicial review of reimbursement claims that are dependent upon "a question of law or regulations" (42 U.S.C. (& Supp. III) 1395*oo*(*f*)(1)), Congress expressly required presentation of the matter to the intermediary, even though the intermediary lacks the authority to rule on such matters (see page 15, *supra*).[20]

Moreover, the PRBB is subject to the same constraint as an intermediary—it cannot overturn regulations. Yet, prior to the creation of the right to expedited judicial review, such claims had to be heard by the Board; indeed, the whole rationale for the expedited review provision was that it would allow providers to avoid the formality of a Board hearing concerning such claims. The mere fact that the intermediary lacks authority to award reimbursement on the ground claimed by the provider accordingly does not provide a basis for distinguishing between those situations in which a claim must be raised before the intermediary and those in which it need not.

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[20] Indeed, the structure of the expedited review provision makes clear that such claims must be raised before the intermediary. When a provider files a request seeking a determination by the Board with respect to its authority to consider the provider's claim, the Board must act on the request within 30 days (42 U.S.C. (& Supp. III) 1395*oo*(*f*)(1)). That relatively brief period is plainly insufficient to allow the Board to undertake a thorough review to determine in the first instance whether "[the Board] is without authority to decide the question" (*ibid.*). The Board must make use of the the intermediary's evaluation of that question. See page 32, *infra*. With respect to this type of claim, therefore, it is clear that Congress intended that the matter be raised before the intermediary.

Furthermore, the policies that support the general requirement that claims be raised before the intermediary also support the imposition of that requirement in the present context. This Court has recognized that even where an administrative tribunal lacks authority to grant the relief sought by a party, the agency should nevertheless be allowed to determine whether the claim does in fact turn upon the challenge to the governing regulation or statute, as well as whether the claim is otherwise invalid or cognizable under a different statutory or regulatory provision. See *Heckler* v. *Ringer*, 466 U.S. 602, 618-620 & n.12, 623-624 (1984); *Weinberger* v. *Salfi*, 422 U.S. 749, 765 (1975). Here, the intermediary might find a provider's claim barred for a reason other than the standard contained in the regulation challenged by the provider. Alternatively, the intermediary could find that the provider was entitled to the claimed reimbursement on grounds that render the challenge to the regulation moot. Cf. *Heckler* v. *Ringer*, 466 U.S. at 619-620 n.12. Finally, consideration of these claims by the intermediary is useful to the Secretary's overall administration of the Medicare program. Intermediaries have suggested changes in cost reimbursement rules on the basis of experience gained in considering challenges to those rules.[21]

Apart from their contention that the Secretary's interpretation of the statute is not reasonable, petitioners also assert (Br. 37-41) that deference to the Secretary's interpretation of the statute is inappropriate because that interpretation is not embodied in a regulation, was not

[21] Petitioners contend (Br. 30-31) that the reasons underlying Congress's decision to allow providers to avoid PRRB review of claims based upon regulatory challenges are equally applicable here. What petitioners ignore is that, unlike a PRRB hearing, the cost report is not issue specific; every provider must file a cost report that is then evaluated by a fiscal intermediary. Since the cost report must be filed in any event, it is logical to require a provider to include all of its reimbursement claims in that document.

developed at the time of the enactment of the statute, has not been consistently adhered to, and is tainted by the Secretary's alleged hostility to judicial review. None of these arguments provides any basis for discounting the deference accorded to the Secretary's construction of the statute.

First, contrary to petitioners' apparent belief, an administrative agency's interpretation of a statute need not be embodied in a regulation in order to be entitled to deference. Where, as here, the agency construes the statute it is charged with administering in the course of an adjudicatory proceeding, the agency's determination is also entitled to deference. See, *e.g.*, *Fall River Dyeing & Finishing Corp.* v. *NLRB*, No. 85-1208 (June 1, 1987), slip op. 14. In fact, the Secretary's interpretation at issue here is set out in the Medicare Provider Reimbursement Manual, a publication issued by the Secretary as a guide for Medicare providers. The manual states that "[p]roviders are permitted to dispute regulatory and policy interpretations through the appeals process established by the Social Security Act. The provider must include the nonallowable item in the cost report in order to establish an appeal issue" (2 Medicare and Medicaid Guide (CCH) ¶ 9115).[22]

[22] The provision quoted in the text is the current version, which was issued in July 1981. The prior version of the provision, dated September 1980, states (Medicare Provider Reimbursement Manual, Part II-Provider Cost Reporting Forms and Instructions, Transmittal No. 4):

> Providers that include nonallowable cost on a cost report may do so where the cost report item has been disputed and the provider clearly discloses this particular item is being included in the cost report only to establish the basis for an appeal. Nonallowable cost items may have been determined from the intermediary audit or desk review of the provider's prior year cost report or from provider adjustments to the cost report which are supported by decisions of the intermediary's hearing officer or the Provider Reimbursement Review Board, even though such decisions have been subsequently overruled by the Administrator.

The manual provision is essentially a codification of the rule applied by the Secretary and the Board in individual reimbursement decisions.[23]

Second, although petitioners are correct that the Secretary did not address the present issue at the time of the establishment of the PRRB, that fact is of little moment in the circumstances of this case. As we have discussed, the PRRB was placed atop a preexisting administrative process under which intermediaries were afforded complete responsibility for the determination of providers' reimbursement claims. Since, of necessity, all claims were presented to the intermediary under the old system, it would have been quite logical to assume that intermediaries would continue to consider all claims in the new system. When cases came before the Board in which providers failed to present claims to their intermediary, the Board, and then the Secretary, adopted the interpretation of the statute that is at issue in this case. In these circumstances, the fact that the Secretary's interpretation of the statute was not adopted at the time of the statute's enactment does not justify a reduction in the weight accorded the Secretary's interpretation.

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[23] See, *e.g.*, *LAC Weighted Ancillary Group Appeal* v. *Blue Cross and Blue Shield Ass'n*, [New Developments] Medicare & Medicaid Guide (CCH) ¶ 34,866, at 9323 (PRRB 1985); *Virginia Hospital Labor and Delivery Room Days Appeal Group* v. *Blue Cross and Blue Shield Ass'n*, [New Developments] Medicare & Medicaid Guide (CCH) ¶ 33,517, at 9524 (HCFA 1983); *Mt. Zion Hospital-Hill Burton Group Appeal* v. *Blue Cross and Blue Shield Ass'n*, [New Developments] Medicare & Medicaid Guide (CCH) ¶ 32,370, at 9840-9841 (PRRB 1982); *Sacramento-Sierra Hospital Group Appeal* v. *Blue Cross Ass'n*, [New Developments] Medicare & Medicaid Guide (CCH) ¶ 31,701, at 10255 (PRRB 1982); *American Hospital Ass'n Group Appeal* v. *Blue Cross Ass'n* [New Developments] Medicare & Medicaid Guide (CCH) ¶ 30,786, at 9409-9411 (HCFA 1980); PRRB Decision No. 77-D61, [New Developments] Medicare & Medicaid Guide ¶ 28,657, at 10289-10290, 10291 (1977) aff'd, [New Developments] Medicare & Medicaid Guide (CCH) ¶ 28,698, at 10453-10454 (HCFA 1977); see also *Athens Community Hospital, Inc.* v. *Schweiker*, 743 F.2d at 8 & n.12 (collecting cases).

Third, petitioners argue that the Secretary's interpretation of the statute has been inconsistent, citing four Board decisions that assertedly conflict with the Board's decision in the present case. But the decisions cited by petitioners are not inconsistent with the Secretary's present position in this case. As petitioners themselves recognize (Br. 13-14), there is a difference between a provider's right to invoke the Board's jurisdiction and the scope of the Board's remedial authority in a case that is properly before it. The present case involves the former question, while the allegedly inconsistent decisions all involve the latter issue.[24] The Secretary has in fact maintained a single con-

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[24] In *Unity Hospital* v. *Blue Cross Ass'n*, [New Developments] Medicare & Medicaid Guide (CCH) ¶ 31,097 (PRRB 1981), for example, the Board found that, because the provider's cost report was "properly before the Board" without considering an issue the provider failed to raise in its cost report, the Board could utilize its residual authority under Section 1395*oo*(d) to consider that issue in the first instance (¶ 31,097, at 10407). The Board distinguished *American Hospital Ass'n* v. *Blue Cross Ass'n*, [New Developments] Medicare & Medicaid Guide (CCH) ¶ 30,786 (HCFA 1980), in which the Board was found to lack jurisdiction over a claim not raised before the intermediary, on the ground that "the jurisdiction question [in *American Hospital Ass'n*] dealt with a provider who did not have a cost report properly before the Board" (¶ 31,097 at 10407).

Thus, because the provider in *Unity Hospital* had a right to Board review with respect to an issue raised before the intermediary, the Board had jurisdiction over the case and could exercise its discretionary authority to consider an issue not raised before the intermediary. The other decisions cited by petitioners are to the same effect. *Ravenswood Hospital Medical Center* v. *Blue Cross Ass'n*, [New Developments] Medicare & Medicaid Guide (CCH) ¶ 31,945, at 9608 (PRRB 1982); *St. Joseph Medical Center* v. *Blue Cross Ass'n*, [New Developments] Medicare & Medicaid Guide (CCH) ¶ 30,925, at 9855-9856 (PRRB 1981); see also *University Park Convalescent Center* v. *Aetna Life & Casualty Co.*, [New Developments] Medicare & Medicaid Guide (CCH) ¶ 30,993 (HCFA 1981).

Petitioners argue (Br. 38-39) that *Charter Peachford Hospital, Inc.* v. *Bowen*, 803 F.2d 1541 (11th Cir. 1986), is another case in which the Board considered an issue not raised before the intermediary. The cost

sistent position with respect to a provider's right to invoke the Board's jurisdiction: the provider is entitled to a hearing before the Board only when it seeks review of an issue that was raised before its intermediary. After that jurisdictional requirement is satisfied the Board may, on its own motion, exercise its discretionary authority to consider issues not raised before the intermediary. Because of the absence of any inconsistency, there are no grounds for discounting the Secretary's interpretation of the statute.[25]

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report in that case was before the Board on several matters unrelated to the issue not raised before the intermediary. See *Charter Peachford Hospital* v. *Mutual of Omaha Ins. Co*, [New Developments] Medicare and Medicaid Guide (CCH) ¶ 34,102 (PRRB 1984). Accordingly, the Board's decision to exercise its residual discretionary jurisdiction falls in the same category as the decisions just discussed. Moreover, as the transcript of the Board hearing shows (see J.A. 64a-67a), the unraised issue was actually subsumed in an issue that was contested before the intermediary. In view of that "unusual" circumstance, the Board decided to exercise its discretionary authority to consider the unraised issue (*id.* at 67a).

[25] Even if the four Board decisions cited by petitioners did deviate from the Secretary's construction of the statute, they would be insufficient to discredit the many other decisions consistent with the ruling in this case. Especially in a program as vast as the Medicare program, more than a few stray decisions should be required before no deference can be accorded to the basic position asserted by the Secretary. This Court has observed that "[a]n agency interpretation of a relevant provision which conflicts with the agency's earlier interpretation is 'entitled to considerably less deference' than a consistently held agency view" (*INS* v. *Cardoza-Fonseca*, No. 85-782 (Mar. 9, 1987), slip op. 25 n.30 (citation omitted)). The Court applied that principle in *Cardoza-Fonseca* on the basis of its conclusion that the agency had exhibited a "long pattern of erratic treatment" of the question of statutory interpretation presented in that case (*id.* at 25-26 n.30). Absent repeated, express shifts in position such as those present in *Cardoza-Fonseca*, however, there is no basis for discounting the Secretary's interpretation of the statute.

Fourth, petitioners cite no authority for their novel contention that no deference is due to the statutory interpretations of an agency whose interpretations have sometimes been rejected by the courts. It is the agency, not the courts, that is the entity chosen by Congress to administer the Medicare statute. The fact that some courts have disagreed with the Secretary's interpretation of the statute cannot by itself be sufficient to render the Secretary's position unreasonable. Any other result would dramatically reduce an agency's authority to construe the statutes it is charged with administering, thereby undercutting the important policies underlying the principle of judicial deference to agency action. See, *e.g.*, *Chevron U.S.A. Inc.* v. *NRDC*, 467 U.S. at 865-866.

In any event, petitioners suggest no standards to determine whether an agency's "batting average" in court is sufficiently high to warrant continued deference to its statutory constructions. We submit that any such standard would be inherently arbitrary, and would in effect constitute judicial second-guessing of Congress's decision to commit the administration of a statute to the agency's expertise.

Finally, the Secretary's position should not be discounted because of an alleged hostility to judicial review. The Secretary's various prior positions were quite reasonable in light of the fact that the governing statute made no provision for administrative or judicial review of intermediaries' determinations and, in fact, contained a provision precluding such review (see 42 U.S.C. (& Supp. III) 405(h)).[26] Indeed, the providers that petitioned Congress for the adoption of a statute permitting administrative and judicial review, as well as Congress itself, recognized that such review was not available under the

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[26] This provision is made applicable to the Medicare statute by 42 U.S.C. (& Supp. III) 1395ii.

Act. See pages 22-23, *supra*. And when Congress did create rights to judicial review, it did so on an incremental basis (see page 24, *supra*), thus providing further support for the Secretary's position that the original statute did not authorize wholesale judicial review.

In sum, the Secretary's settled interpretation of the statute—that a provider has a right to Board review only with respect to an issue raised before an intermediary—is reasonable and should be upheld by this Court.

4. Providers Had Notice That They Would Be Entitled To Invoke The Board's Jurisdiction Only With Respect To Reimbursement Claims Raised Before Their Intermediaries

Petitioners contend (Br. 44-46) that even if the Secretary has correctly interpreted the statute, the jurisdictional bar cannot be applied to them because the Secretary did not provide prior notice of the requirement that all reimbursement claims must be included in the cost report. Petitioners do not appear to assert that they failed to claim reimbursement on *their* cost reports because they had no notice that such a course of action was necessary; and no evidence of any such reliance was introduced before the PRRB. Moreover, any such claim would be highly suspect in view of the fact that the vast majority of providers did raise all of their reimbursement claims in their cost reports. In the present case, for example, 25 of the 27 providers that challenged the 1979 rule governing reimbursement for malpractice insurance costs had raised the issue on their cost reports. See also *Tallahassee Memorial Regional Medical Center* v. *Bowen*, 815 F.2d 1435, 1441 (11th Cir. 1987), petition for cert. pending, No. 87-380 (30 of 35 hospitals raised issue on their cost reports); *Athens Community Hospital, Inc.* v. *Schweiker*, 743 F.2d at 10 (observing that 71 of 72 hospitals in a companion case claimed the disputed cost on their cost reports).

In any event, as we have discussed (at 11-38), the statute, legislative history, and administrative decisions provided ample notice of this requirement. Since all claims had to be presented to the intermediary prior to the creation of the PRRB, and neither Congress nor the Secretary altered that preexisting practice after the Board was created, providers had no grounds for concluding that circumvention of the intermediary had become permissible.[27] And the Secretary and the PRRB had held several times—prior to the filing of the cost reports at issue in this case—that a provider could not invoke the Board's jurisdiction with respect to a claim that was not raised before its intermediary. See page 34 note 23, *supra*. For these reasons, Medicare providers had more than sufficient notice of the Secretary's intepretation of the statute.

B. Even if the Board Has The Power to Hear A Case In Which A Provider Did Not Raise Its Claim Before The Intermediary, The Board May Exercise Discretion To Decline To Hear Such A Case

Even if the Court were to reject our submission and conclude that the Board's jurisdiction may be invoked by a claim not previously presented to the intermediary in the cost report, a provider would not necessarily be entitled to compel the Board to adjudicate such a claim in every case. We submit that the Board would have broad discretion to decline to hear such a claim, and that such discretion was properly exercised on the facts of this case.

The general rule in judicial proceedings is that an appellate court will not consider an issue raised for the first time on appeal. This general rule is justified by considera-

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[27] Indeed, as we have noted, the very portion of the statute upon which petitioners relied before the Board—the expedited judicial review provision—applies by its terms only to an "action" of the fiscal intermediary.

tions of judicial economy and the advantages of full consideration of the legal issues and development of the factual record in the trial court. The general rule is, of course, subject to exceptions for jurisdictional questions and situations where failure to hear the claim would result in exteme unfairness. *Hormel* v. *Helvering*, 312 U.S. 552, 557-559 (1941); *National Fidelity Life Insurance Co.* v. *Karaganis*, 811 F.2d 357, 360-361 (7th Cir. 1987); *District of Columbia* v. *Air Florida, Inc.*, 750 F.2d 1077, 1084-1085 (D.C. Cir. 1984); *In re Southland Supply, Inc.*, 657 F.2d 1076, 1079 (9th Cir. 1981).[28]

As we have discussed (at 26-32), substantially the same policy reasons weigh against the exercise of Board jurisdiction over claims that were not first presented to the intermediary. The PRRB should be free to exercise the same wide discretion in determining whether to consider a claim that was not raised before the intermediary. Indeed, the Board's discretion should, if anything, be broader than that exercised by a court. Unlike the typical situation in an appellate court, where a party seeks to raise a new legal argument justifying its prayer for relief in the lower court, a provider that raises a new reimbursement claim before the Board is seeking entirely new relief. The situation is

[28] This Court recently recognized these principles in upholding, as an exercise of a court's inherent supervisory power, a rule requiring a party to object to a magistrate's report before the district court in order to obtain review of those issues in the court of appeals. See *Thomas* v. *Arn*, 474 U.S. 140 (1985). The Court observed that this rule, "by precluding appellate review of any issue not contained in objections, prevents a litigant from 'sandbagging' the district judge by failing to object and then appealing" (*id.* at 147-148). The Court further stated that the rule prevented the "inefficient use of judicial resources" because, "[a]bsent such a rule, any issue before the magistrate would be a proper subject for appellate review. This would either force the court of appeals to consider claims that were never reviewed by the district court, or force the district court" to review every issue in the case (*id.* at 148).

akin to a tort action in which—after the case is on appeal—the plaintiff seeks to present new evidence showing a right to increased damages due to injuries that were not claimed in the trial court. For these reasons, the Board should have discretion to conclude that, as a general matter, it will not consider a reimbursement claim that was not raised before the intermediary and is instead advanced for the first time when the appeal is brought before the Board—even if the Court were to reject our primary submission that Congress has mandated that result.[29]

CONCLUSION

The judgment of the court of appeals should be affirmed.

Respectfully submitted.

LAWRENCE G. WALLACE
*Acting Solicitor General**
RICHARD K. WILLARD
Assistant Attorney General
THOMAS W. MERRILL
Deputy Solicitor General
ANDREW J. PINCUS
Assistant to the Solicitor General

JANUARY 1988

[29] Petitioners assert (Br. 41-44) that the Board should not be allowed to exercise any discretion at all in deciding whether to hear claims not presented to the intermediary. They rely on the general policies in favor of reviewability of administrative action and against unreasonably narrow interpretations of waivers of sovereign immunity. Petitioners completely ignore the general discretion afforded to appellate tribunals to control their dockets and establish reasonable rules of procedure. Moreover, the policies cited by petitioners are entirely inapposite here. There is no preclusion of judicial review in the present case; the Secretary (or, under our principal submission, Congress) has simply established reasonable procedures that a provider must follow in order to avail itself of its rights to an administrative appeal and judicial review. Cf. *Thomas* v. *Arn*, 474 U.S. at 155.

* The Solicitor General is disqualified in this case.

ADDENDUM

42 U.S.C. (& Supp. III) 1395*oo* provides in pertinent part:

(a) Establishment

Any provider of services which has filed a required cost report within the time specified in regulations may obtain a hearing with respect to such cost report by a Provider Reimbursement Review Board (hereinafter referred to as the "Board") which shall be established by the Secretary in accordance with subsection (h) of this section and (except as provided in subsection (g)(2) of this section) any hospital which receives payments in amounts computed under subsection (b) or (d) of section 1395ww of this title and which has submitted such reports within such time as the Secretary may require in order to make payment under such section may obtain a hearing with respect to such payment by the Board, if –

(1) such provider –

(A)(i) is dissatisfied with a final determination of the organization serving as its fiscal intermediary pursuant to section 1395h of this title as to the amount of total program reimbursement due the provider for the items and services furnished to individuals for which payment may be made under this subchapter for the period covered by such report, or

(ii) is dissatisfied with a final determination of the Secretary as to the amount of the payment under subsection (b) or (d) of section 1395ww of this title,

(B) has not received such final determination from such intermediary on a timely basis after filing such report, where such report complied with the rules and regulations of the Secretary relating to such report, or

(C) has not received such final determination on a timely basis after filing a supplementary cost report, where such cost report did not so comply and such supplementary cost report did so comply,

(2) the amount in controversy is $10,000 or more, and

(3) such provider files a request for a hearing within 180 days after notice of the intermediary's final determination under paragraph (1)(A) or with respect to appeals pursuant to paragraph (1)(B) or (C), within 180 days after notice of such determination would have been received if such determination had been made on a timely basis.

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(d) Decisions of Board

A decision by the Board shall be based upon the record made at such hearing, which shall include the evidence considered by the intermediary and such other evidence as may be obtained or received by the Board, and shall be supported by substantial evidence when the record is viewed as a whole. The Board shall have the power to affirm, modify, or reverse a final determination of the fiscal intermediary with respect to a cost report and to make any other revisions on matters covered by such cost report (including revisions adverse to the provider of services) even though such matters were not considered by the intermediary in making such final determination.

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(f) Finality of decision; judicial review; determinations of Board authority; jurisdiction; venue; interest on amount in controversy

(1) A decision of the Board shall be final unless the Secretary, on his own motion, and within 60 days after the

provider of services is notified of the Board's decision, reverses, affirms, or modifies the Board's decision. Providers shall have the right to obtain judicial review of any final decision of the Board, or of any reversal, affirmance, or modification by the Secretary, by a civil action commenced within 60 days of the date on which notice of any final decision by the Board or of any reversal, affirmance, or modification by the Secretary is received. Providers shall also have the right to obtain judicial review of any action of the fiscal intermediary which involves a question of law or regulations relevant to the matters in controversy whenever the Board determines (on its own motion or at the request of a provider of services as described in the following sentence) that it is without authority to decide the question, by a civil action commenced within sixty days of the date on which notification of such determination is received. If a provider of services may obtain a hearing under subsection (a) of this section and has filed a request for such a hearing, such provider may file a request for a determination by the Board of its authority to decide the question of law or regulations relevant to the matters in controversy (accompanied by such documents and materials as the Board shall require for purposes of rendering such determination). The Board shall render such determination in writing within thirty days after the Board receives the request and such accompanying documents and materials, and the determination shall be considered a final decision and not subject to review by the Secretary. If the Board fails to render such determination within such period, the provider may bring a civil action (within sixty days of the end of such period) with respect to the matter in controversy contained in such request for a hearing. Such action shall be brought in the district court of the United States for the judicial district in which the provider is located (or, in an action brought jointly by several providers, the judicial district in which the greatest number of such providers are located) or in the District

Court for the District of Columbia and shall be tried pursuant to the applicable provisions under chapter 7 of title 5 notwithstanding any other provisions in section 405 of this title. Any appeal to the Board or action for judicial review by providers which are under common ownership or control or which have obtained a hearing under subsection (b) of this section must be brought by such providers as a group with respect to any matter involving an issue common to such providers.

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